

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7397

CERTIFICATE OF DEATH

ITEM & FILM G294 9/13/61 iwk

07387

1. PLACE OF DEATH e. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY in 1b 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		d. STREET ADDRESS 121 WEST SECOND ST.	
3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last ADAMS		4. DATE OF DEATH Month JULY Day 30 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-24-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR		11. BIRTHPLACE (County & State, or foreign country) W.VA.-St. George	
13. FATHER'S NAME WILLIAM F. ADAMS		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes War I		16. SOCIAL SECURITY NO. 705-09-7798	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) acute myocardial infarction DUE TO obstruction of the colon DUE TO adenocarcinoma of splenic flexure colon		INTERVAL BETWEEN ONSET AND DEATH 10 days 2 weeks 6-8 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/24/61 to 7-30-61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred 10:12 P.M. the causes and on the date stated above.		22a. SIGNATURE Richard E. Schindler M.D. 22c. PHYSICIAN'S NAME (Type) DR. RICHARD SCHINDLER	
22b. DATE SIGNED		22d. ADDRESS 69 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		23d. LOCATION (City, town or county) (State) Terra Alta, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25. REC'D BY REGISTRAR DATE AUG 7 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7398

07388

1. PLACE OF DEATH e. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 201 GRAND AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLIFTON A. APPELL		4. DATE OF DEATH Month JULY Day 4 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 5, 1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter Foreman Railroad		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA Manning	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN APPELL	
14. MOTHER'S MAIDEN NAME HANNAH STOBBS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 705-05-1789		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO (b) Acute Coronary Occlusion (c) Chronic Coronary Fibrosis - Chronic Bronchitis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH months. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 61 , to July , 19 61 , that (I) (we) last saw the deceased alive on July 3 , 19 61 , and that death occurred at 5:45 AM on the causes and on the date stated above.			
22a. SIGNATURE DR. G. OVERTON HIMMELWRIGHT		22b. DATE SIGNED 7/6/61	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-6-61	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland Md.		25. REC'D BY REGISTRAR JUL 10 '61	
25b. REGISTRAR'S SIGNATURE William S. Harris			

07338

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

1 DAY

CUMBERLAND

501 GRAND AVENUE

MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES.

APRIL

A.

CLINTON

DECEMBER 5, 1955

MALE WHITE

REGISTERED CARPENTER FOREMAN HILLTOP WEST VIRGINIA HILLTOP U.S.A.

HANNA STREET

JOHN APRIL

705-05-1750 MEMORIAL HOSPITAL - CUMBERLAND, MD.

Handwritten notes:
John April, Carpenter
Hilltop West Virginia
Hilltop U.S.A.

133 VIRGINIA AVE., CUMBERLAND, MD.

DR. GAVIN HINCHES

133 VIRGINIA AVE., CUMBERLAND, MD.

705-05-1750

James E. Gault, Cumberland, MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

7399 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07389

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cumberland R.F.D. Rt. 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl Frederick John Bierman		4. DATE OF DEATH July 27, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1889
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick Bierman	
14. MOTHER'S MAIDEN NAME Minnie Schultz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Carl Bierman, Jr. R.F.D. Rt. 4, Cumberland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Benedict Skitarelic M.D.		DATE SIGNED July 27, 1961	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 30, 1961	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS 108 Va. Ave. Cumberland, Md.		24a. REC'D BY REGISTRAR Aug 2 '61 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

(I)

MEDICAL CERTIFICATION



1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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7400
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7400
CERTIFICATE OF DEATH
07390

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 49 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 517 Maryland Ave.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 517 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Harold		First G.		Middle Bolinger		Last July		4. DATE OF DEATH Month 1 Day 19 Year 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1912		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Contractor				10b. KIND OF BUSINESS OR INDUSTRY Self Employed				11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Marry G. Bolinger				14. MOTHER'S MAIDEN NAME Maude Eyler											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes War II				16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Maude Bolinger, Cumberland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Tumor Throat Cord 196-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 2 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from July 1, 1961 to July 1, 1961 , that (I) (we) last saw the deceased alive on July 1, 1961 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.															
22a. SIGNATURE Dr. Blane M. Schindler						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/3/61		22c. PHYSICIAN'S NAME (Type) Dr. Blane M. Schindler							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 3, 1961		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery				23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE JUL 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

7000

07030

(M)

(I)

Allegany

Maryland

Allegany

Cambridge

40 years

Cambridge

314 Maryland Ave.

314 Maryland Ave.

Altoona

G. Bolinger

July 1

31

White

April 22, 1912

General Court over Ball involved Cambridge, Md.

Kerry G. Bolinger

Wanda Tyler

W 2 II

Yes

Mrs. Enoch Bolinger, Cambridge, Md.

Handwritten signature

Handwritten signature

Dr. Blane E. Schindler

40 Green St., Cambridge, Md.

July 2, 1912 Green Court Cemetery

Cambridge, Md.

Green St., Cambridge, Md.

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DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07391

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 157 MAPLE ST.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last BRODE		4. DATE OF DEATH Month JULY Day 22 , Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COAL MINER		12. KIND OF BUSINESS OR INDUSTRY F'BG. FUEL CO.	
13. FATHER'S NAME CONRAD BRODE		14. MOTHER'S MAIDEN NAME JENNIE MASON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-097-325	
17. INFORMANT MRS. BESSIE BRODE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Acute Cardiac Distention Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarction (a), stating the underlying cause last. (c) 3 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 22, 1961 to July 22, 1961 , that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred July 22, 1961 from the causes and on the date stated above.			
22a. SIGNATURE W. O. MC LANE		22b. DATE SIGNED July 24, 1961	
22c. PHYSICIAN'S NAME (Type) W. O. MC LANE, M.D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-24-1961	
23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		25a. REC'D BY REGISTRAR JUL 25 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7402

CERTIFICATE OF DEATH

07392

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/17/59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			d. STREET ADDRESS Rt. 5, (Triple Lake)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lewis Middle John Last Broome			4. DATE OF DEATH Month July Day 30 , Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/1872		9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Store Proprietor/Grocery		10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME John Edward Broome			14. MOTHER'S MAIDEN NAME Harriet Frances Rice		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. P.O.Box 599, Cumberland, Md.		
17. INFORMANT Allegany County Infirmary Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, chronic, Saccular 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis, DUE TO (c) Cerebral distention					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 8/17/59 , 19____, to 7/30/61 , 19____, that (I) (we) last saw the deceased alive on 7/29/61 , 19____, and that death occurred at ____ M., from the causes and on the date stated above.					
22a. SIGNATURE Dr. Lee B. Mathews		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 7/31/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/1/61		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.	
23d. LOCATION (City, town, or county) Fort Ashby, W. Va.					
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George			ADDRESS Cumberland, Md.		
25a. REC'D BY REGISTRAR DATE AUG 3 '61			25b. REGISTRAR'S SIGNATURE Carling L. Hume		

03252

CERTIFICATE OF DEATH

1902

(M)

Allegany

West Virginia

Allegany

Underland

031752

Underland

Allegany County, West Virginia

Allegany County, West Virginia

July 1902

Underland

1902

Underland

29

1902

Underland

U. S. A.

Allegany County, West Virginia

Allegany County, West Virginia

Allegany County, West Virginia

Underland

Allegany County, West Virginia

1902

1902

1902

Allegany County, West Virginia

1902

1902

1902

Allegany County, West Virginia

Allegany County, West Virginia

1902

1902

1902

Allegany County, West Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07393

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS 78X-3	
3. NAME OF DECEASED (Type or print) First CHARLES Middle O. Last BURNS		4. DATE OF DEATH Month JULY Day 18, Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18	11. IF UNDER 24 HRS. Hours 18 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business man		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK BURNS		14. MOTHER'S MAIDEN NAME ALLIE WHITTAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 197-03-7752A	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction partial and complete 570.5 DUE TO Adhesions - post operative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic vascular disease - with cerebral thrombosis 4 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) with cerebral thrombosis 4 days			
INTERVAL BETWEEN ONSET AND DEATH 20 yrs 2 wks 20 yrs. approx 3 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 18, 1961 9:40 P.M. to July 18, 1961 , that (I) (we) last saw the deceased alive on July 18, 1961 , and that death occurred at July 18, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE Wylie M. Faw		22b. DATE SIGNED July 19, 1961	
22c. PHYSICIAN'S NAME (Type) DR. JOHN DOCK		22d. ADDRESS HYNDMAN, PA.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1961	
23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City, town or county) (State) Hyndman, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey A. Leigler		25a. REC'D BY REGISTRAR JUL 24 '61	
ADDRESS Hyndman, Pa.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

6050

Y. A. Z. 1A

2Y10-8

GENERAL HOSPITAL
GENERAL & WARRICK AVES.

CHARLES

Y-396

103-1-5

STIM

3100

2000

and control

4117-1729-39

TRANSMISSION 2133

197-02-775408AL HOSPITAL - CUMBERLAND, MD.

Hyman, P.

July 28, 1961 Ryman Cemetery

Index

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7404

CERTIFICATE OF DEATH

Reg. Dist. No. 07394

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. LENGTH OF STAY IN 1b 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 Center St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle John Last Capel		4. DATE OF DEATH Month July Day 5 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1882
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 12 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Fayette Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Capel		14. MOTHER'S MAIDEN NAME Eliza Shriver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 220-07-6851	
17. INFORMANT Mr. Harold McKenzie		Address Cumb. Md. 583 Arnett Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hrs ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 0 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5, 1961 , to July 5, 1961 , that I last saw the deceased alive on July 5, 1961 , and that death occurred at 6:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W O McLane M.D.		ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED July 7/1961	
PHYSICIAN'S NAME (Type) W O McLane M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/61	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Pearl Mattingly		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR JUL 10 1961		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH	
EDUCATION		RELIGION	
MARRIAGE		SINGLE	
PREVIOUS ILLNESS		DATE OF ONSET	
TREATMENT		HOSPITAL	
PHYSICIAN		NURSE	
CORONER		BURIAL	
INTERVIEW		DATE	
SIGNATURE		DATE	
WITNESS		DATE	
FAMILY		DATE	
FRIENDS		DATE	
CLERGY		DATE	
FUNERAL		DATE	
BURIAL		DATE	
Cremation		DATE	
Other		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
7405																			
CERTIFICATE OF DEATH																			
07395																			
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 HOUR d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY d. STREET ADDRESS Fort Ashby e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) HARRY					4. DATE OF DEATH Month JULY Day 5 Year 19 61														
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 2, 1903		9. AGE (In years last birthday) 57 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10b. KIND OF BUSINESS OR INDUSTRY ALLEGANY BALLASTIC		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.											
13. FATHER'S NAME JOHN CHESHIRE (DECEASED)					14. MOTHER'S MAIDEN NAME JESSIE Edna Rollins														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 214-07-0157					17. INFORMANT PATIENT'S CHART									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hours																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) Fort Ashby					20g. (County) MINERAL					20h. (State) WEST VIRGINIA									
21. I certify that (I) (this hospital) attended the deceased from January 1960 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 and that death occurred at 11:00 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE B. M. Schindler					22b. DATE SIGNED JUL 11 '61														
22c. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.					22d. ADDRESS GREEN ST., CUMBERLAND, MARYLAND														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 7-8-61					23c. NAME OF CEMETERY OR CREMATORY Fort Ashby, Cem.									
23d. LOCATION (City, town or county) Fort Ashby, W.VA.					23e. REC'D BY REGISTRAR JUL 11 '61					23f. REGISTRAR'S SIGNATURE Arthur S. Hines									

05335

1905

(17)

(1)

James F. [illegible]
Fort Army, Va.
1905

James F. [illegible]
Fort Army, Va.
1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7406

07396

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W.Va. b. COUNTY Mineral					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 14 Silver St.					
3. NAME OF DECEASED (Type or print) Charles Henry Coffman				DATE OF DEATH July 10 19 61					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1897			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainance Foreman Town of Ridgeley		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
11. BIRTHPLACE (County & State, or foreign country) Ridgeley, W. Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edward S. Coffman				14. MOTHER'S MAIDEN NAME Jenny Zimmerman W. Va.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 232-10-2759					
17. INFORMANT Mrs. Aletta F. Coffman				Address 14 Silver St., Ridgeley,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-4, 1957 , to 7-10, 1961 , that (I) (we) last saw the deceased alive on 7-10, 1961 , and that death occurred 7:25 P.M., from the causes and on the date stated above.									
22a. SIGNATURE R. W. Ballin				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.				22d. ADDRESS 62 GREENE ST.; CUMBERLAND, MD. 7-12-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/61		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 14 '61 25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

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(M)

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Corporal James H. ...

James H. ...

3 - 11 27 7 - 10

7:30

7 - 10

7-11-11

7-11-11

James H. ...

James H. ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07397**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 114 Mt. Pleasant Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last CONNELLEY				4. DATE OF DEATH Month 7 Day 17 Year 1961											
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-1906		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 7 Days 17		IF UNDER 24 HRS. Hours 17 Min. 1961			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereotype-pressman				10b. KIND OF BUSINESS OR INDUSTRY Times & Allegan Co				11. BIRTHPLACE (State or foreign country) Frostburg				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick Connelley						14. MOTHER'S MAIDEN NAME Anna Metzner									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. II				16. SOCIAL SECURITY NO. 220-10-2127				17. INFORMANT Joseph T. Connelley				Address Cumberland, Md. 531 N. Center St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, LEFT VENTRICLE, Large DUE TO 42011 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) CORONARY SCLEROSIS, OLD; THROMBOSIS, RECENT												INTERVAL BETWEEN ONSET AND DEATH 1-2 years it			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 17, 1961															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-20-61		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery Frostburg				22d. LOCATION (City, town, or county) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hafer Funeral Home</i> 23 E. Main, Frostburg, Md.						24a. REC'D BY REGISTRAR DATE JUL 21 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be returned within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7408
CERTIFICATE OF DEATH

07398

1. PLACE OF DEATH e. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CIMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		d. STREET ADDRESS <u>1129 MT. PLEASANT STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>M</u> Last <u>CONNOR</u>		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>19 61</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/89</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BERNARD MURPHY</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR BEVIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-3730A</u>	
17. INFORMANT <u>CHART</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis Cardiovascular - Degenerative</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes mellitus</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>56 hours</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>8</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>	20f. (City or town) <u>X</u> (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> <u>1968</u> <u>to</u> <u>7/22</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> <u>1961</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin Rothstein M.D.</u>		22b. DATE SIGNED <u>7/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin Rothstein, M. D.</u>		22d. ADDRESS <u>48 Broadway, Frostburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Frostburg, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Burt</u>		25. REC'D BY REGISTRAR <u>Arthur S. Kenna</u>	
ADDRESS <u>Frostburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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67-07-070

7-25-61

Worcester, MA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7409

07399

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY in 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. d. STREET ADDRESS 107 MEMORIAL AVE. EXT. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLYDE D COOK, JR.		4. DATE OF DEATH JULY 16 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-1946
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 15 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CLYDE D. COOK, SR.		14. MOTHER'S MAIDEN NAME FRANCES GROVE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) MUSCULAR DYSTROPHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. and PNEUMONIA Rt Mid Lobe (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 13 years 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/14/61 to 7/16/61 , that (I) (we) last saw the deceased alive on 7/16/61 , and that death occurred at 2:30 P.M. the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		22b. DATE SIGNED 7/17/61	
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-20-61	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 21 '61 25b. REGISTRAR'S SIGNATURE [Signature]	

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WILSON

WILSON

WILSON

CUMBERLAND, MD.

2 DAYS

CUMBERLAND, MD.

107 MEMORIAL AVE. EXT.

MEMORIAL HOSPITAL
107 MEMORIAL AVE.

JULY 13 1941

COOK, JR.

10

CLYDE

1-25-1946

WHITE

WHITE

CUMBERLAND, MD.

STUDENT

FRANCIS GRIFF

CLYDE O. COOK, SR.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

STONE

NO

20 GREEN ST., CUMBERLAND, MD.

DR. S. S. WEISMAN

CUMBERLAND, MD.

Samuel Butler Park

7-80-61

CUMBERLAND, MD.

James I. Scarpelli

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7410

07400

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN lb 5 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 19 Mill Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Dewey Dickey		4. DATE OF DEATH July 4th, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24th, 1899
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Foreman		10b. KIND OF BUSINESS OR INDUSTRY Refractories	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Dickey		14. MOTHER'S MAIDEN NAME Elizabeth Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 182-01-4160	
17. INFORMANT Mrs. Ethel J. Dickey		Address 19 Mill Street, Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cor Pulmonale - (c) Silicosis		INTERVAL BETWEEN ONSET AND DEATH 3 months 4 yrs. ? 10 yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Month, Day, Year Hour e.m. X p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that (I) (this hospital) attended the deceased from JUNE 19 66 to 7/4 , 19 61 , that (I) (we) last saw the deceased alive on 7/4 , 19 61 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein		22b. DATE SIGNED 7/6/61	
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein,		22d. ADDRESS 48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-7-61	
23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Burst		25a. REC'D BY REGISTRAR JUL 10 '61	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. K...	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7411

07401

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Doyle Last Doyle				4. DATE OF DEATH Month July Day 14 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1901	
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min.		IF UNDER 24 HRS. Months 1 Days 14 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Jones				14. MOTHER'S MAIDEN NAME Rose Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT James Doyle Address Lonaconing, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — "Husband"							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of INTESTINES 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month X Day 19 Year 1961 Hour a. m. p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nonwhile <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JUNE 1960 to 7/14 1961 that (I) (we) last saw the deceased alive on 7/14 1961 and that death occurred on 7/14 1961 from the causes and on the date stated above.							
22a. SIGNATURE Martin M. Rothstein M.D.				22b. DATE SIGNED 7/16/61			
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.				22d. ADDRESS 48 BROADWAY - FROSTBURG, MD.			
23a. BURIAL, CREMATION, or removal (Specify) Burial		23b. DATE THEREOF 7/17/61		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.				25a. REC'D BY REGISTRAR DATE JUL 19 61		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

MEDICAL CERTIFICATION

7412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>700 Lincoln St.</u>		d. STREET ADDRESS <u>700 Lincoln St</u> 1	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Himmeler</u> Last <u>Eckenrede</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Himmeler</u>		14. MOTHER'S MAIDEN NAME <u>Leopoldina Felinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Albert Sell</u>		Address <u>700 Lincoln St. Cumberland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with left hemiplegia</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension and arteriosclerotic cardiovascular disease</u> DUE TO <u>9 years</u> (c) <u>Diabetes mellitus</u> DUE TO <u>9 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 June</u> , 19 <u>54</u> , to <u>9 July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7 July</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1725 Centre St. Cumberland, Md.</u> DATE SIGNED <u>July 10, 1961</u>			
ACTUAL SIGNATURE <u>W. Alfred Van Ormer</u> M.D.		DATE SIGNED <u>July 10, 1961</u>	
PHYSICIAN'S NAME (Type) <u>W. Alfred Van Ormer, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 11, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7413

CERTIFICATE OF DEATH

07403

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Midland	
3. NAME OF DECEASED (Type or print) First Constance Middle Eisentrou Last trout		4. DATE OF DEATH Month July Day 31 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1875
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY MIDLAND, MO	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Retallic		14. MOTHER'S MAIDEN NAME Rhodda Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Earl Kroll		Address Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 10 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1956 to July 1961 , that (I) (we) last saw the deceased alive on July 31, 1961 , and that death occurred at 2 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Hamilton J. Miles M.D.		22b. DATE SIGNED 8.1.61	
22c. PHYSICIAN'S NAME (Type) L R MILES, JR., M.D.		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/3/61	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		25a. REC'D BY REGISTRAR AUG 4 '61	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Constance L. Hume	

07403

CENTRAL CASE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7414 CERTIFICATE OF DEATH

07404

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 617 MONTGOMERY AVE., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE Washington EMERICK			4. DATE OF DEATH Month Day Year JULY 11 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1888		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired conductor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (County & State, or foreign country) PENNA. Somerset Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME RICHARD EMERICK		
14. MOTHER'S MAIDEN NAME MARTHA KENNEL			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No.		
16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myeloid Leukemia, subacute DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.1 INTERVAL BETWEEN ONSET AND DEATH 2 years					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 29 June 1961 to 11 July 1961 , that (I) (we) last saw the deceased alive on 10 July 1961 , and that death occurred 9:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE W. Alfred Van Ormer M.D.			22b. DATE SIGNED 7/12/61		
22c. PHYSICIAN'S NAME (Type) WILLIAM A. VAN ORMER			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/61		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)	
23g. (City, town or county)		23h. (State)		23i. (Country)	
23j. (City, town or county)		23k. (State)		23l. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George			24b. ADDRESS Cumberland, Md.		
25a. REC'D BY REGISTRAR JUL 14 61			25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7415

CERTIFICATE OF DEATH

07405

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/24/1961	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 540 Eastern Avenue	
3. NAME OF DECEASED (Type or print) First Alice Middle Fetters Last Fetters		4. DATE OF DEATH Month July Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/1873
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Town Creek, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Dicken		14. MOTHER'S MAIDEN NAME Rebecca Ann Robinette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Sickle Cell Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acidemia + Cough DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/24/61 19____, to 7/11/61 19____, that (I) (we) lost saw the deceased alive on 7/11/61 19____, and that death occurred at ____ M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 7/12/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/61	
23c. NAME OF CEMETERY OR CREMATORY Prosperity Christian		23d. LOCATION (City, town, or county) (State) Ner Flintstone, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07406

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Danville, Md.		d. STREET ADDRESS Rt. # 3 Keyser, W. Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Clay Last Flanagan				4. DATE OF DEATH Month July Day 24 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1912		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Red Creek, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harrison Flanagan				14. MOTHER'S MAIDEN NAME Sarah Ketterman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-8063		17. INFORMANT Mrs. Wm. Kammauf, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic				DATE SIGNED 7/25/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/61		22c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		22d. LOCATION (City, town, or county) (State) Near Danville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JUL 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hearn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07407

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 13 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 18 GREENE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH		4. DATE OF DEATH Month Day Year JULY 15 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 7, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS MCCARDELL		14. MOTHER'S MAIDEN NAME ALICE EVE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL AZOTEMIA 570.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) BACTERIAL OR SEPTIC SHOCK (e), stating the underlying cause last. (c) INTESTINAL OBSTRUCTION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 18 HRS. 12 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-12-61 , to 7-15-61 , that (I) (we) last saw the deceased alive on 7-14-61 , and that death occurred at 8:35 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Richard E. Schindler M.D.		22b. DATE SIGNED 8:35 A.M.	
22c. PHYSICIAN'S NAME (Type) RICHARD SCHINDLER, M.D.		22d. ADDRESS 69 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/17/61	
23c. NAME OF CEMETERY OR CREMATORY ROSEHILL CEMETERY		23d. LOCATION (City, town or county) (State) CUMBERLAND MARYLAND	
24 FUNERAL DIRECTOR'S SIGNATURE RUTH E. SILCOX		25a. REC'D BY REGISTRAR JUL 18 '61	
25b. REGISTRAR'S SIGNATURE Robert E. Thomas			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
7418 MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
Item 9 Film G292 2/31/61 iwk 07408															
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 35yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. STREET ADDRESS 205 Lang Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Lang Ave.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Hugh Middle Miller Last Friend				4. DATE OF DEATH Month July Day 24 Year 1961											
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1908		9. AGE (In years last birthday) 52 5/31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fire Nocker Railroad				10b. KIND OF BUSINESS OR INDUSTRY Friendsville, Maryland				11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hugh S. Friend				14. MOTHER'S MAIDEN NAME Mary J. Engle											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Hugh S. Friend 205 Lang Ave				17. INFORMANT Hugh S. Friend 205 Lang Ave				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis (c) Coronary Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden INTERVAL BETWEEN ONSET AND DEATH —															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Benedict Skitarelic				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED July 24, 1961			
EXAMINER'S NAME (Type) Benedict Skitarelic				Address (Street, city, town, or county) Cumberland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-61		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland, Md.									
23. FUNERAL DIRECTOR James F. Scarpelli				ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR JUL 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

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7218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Allegedly

Allegedly

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2012

200 East Ave.

200 East Ave.

Death

Death

Jan. 11, 1908

Received the body of

Received the body of

John J. Friend

John J. Friend

John J. Friend

Coroner's Office

300 East Ave.

300 East Ave.

7-2-81

7-2-81

300 East Ave.

300 East Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07409

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary. Page 1, 2, and 3 of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Harrison ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital--DOA				d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) First THOMAS Middle JEFFERSON Last GATES, Jr.				4. DATE OF DEATH Month July Day 2 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1938	9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months 23 Days 2	IF UNDER 24 HRS. Hours 2 Min. 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY Army		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Gates, Sr				14. MOTHER'S MAIDEN NAME Dorothy Almond			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. Present		17. INFORMANT T. J. Gates, Sr. Address Clarksburg, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 825X DUE TO Skull Fracture, Maceration of Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Automobile accident				INTERVAL BETWEEN ONSET AND DEATH 3-4 Min.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident					
20c. TIME OF INJURY Hour 6:45 e.m. Month, Day, Year July 2 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 220 South of Rawlings, Alleg. Md.		20f. (City or town) (County) (State) Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarellic		M.D. Benedict Skitarellic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 2, 1961	
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.		Address (Street, city, town, or county) Cumberland, MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1961		22c. NAME OF CEMETERY OR CREMATORY Flemington Cemetery		22d. LOCATION (City, town, or country) (State) Flemington, W. Va.	
23. FUNERAL DIRECTOR Byron Kight Cumberland, Md.				24a. REC'D BY REGISTRAR JUL 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

05202

THIS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

(M)

(I)

Memorial Hospital--D.C.

THOMAS, JAMES W. B. JR., JR.

Age 45 years

Sex Male

Color of Hair Brown

Color of Eyes Blue

Color of Skin Fair

Height 5 feet 10 inches

Weight 175 pounds

Build Slender

Occupation Engineer

Marital Status Married

Number of Children 2

Date of Birth July 2, 1918

Date of Death July 2, 1963

Place of Death Memorial Hospital, D.C.

Signature of Medical Examiner

Signature of Physician

Signature of Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7420

07410

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg (Morantown) d. STREET ADDRESS Box 318		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALLISON C. GRIMES		4. DATE OF DEATH Month 7 Day 27 Year 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 7 Days 27 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (County & State, or foreign country) Uniontown, Pa.	
13. FATHER'S NAME William Grimes		14. MOTHER'S MAIDEN NAME Margaret		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 210-03-2702		17. INFORMANT Mrs. Elsie C. Grimes, Box 318	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary insufficiency (c) Atherosclerosis, generalized.		INTERVAL BETWEEN ONSET AND DEATH 25 min 1 hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1961, to July 27, 1961, that (I) (we) last saw the deceased alive on July 27, 1961, and that death occurred at 7:22 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Alvin J. Walters		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Alvin J. Walters		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-31-61		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
23d. LOCATION (City, town or county) Uniontown		(State) Pa.			
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montemurro		25a. REC'D BY REGISTRAR AUG 1 '61		25b. REGISTRAR'S SIGNATURE William L. Hines	
25c. ADDRESS 23 E. MAIN, FROSTBURG, MD.		DATE			

02416

1958

(M)

(I)

Allegany

Proctor

Allegany Hospital

Allegany

H W

Allegany

Allegany

... I

Proctor (Allegany)

Box 218

2-20-1950

Don Williams

Allegany

21-02-1950 Mrs. Elsie A. Williams, Box 218

Alvin J. Williams

James E. Main, Frostburg, Md.

James E. Main, Frostburg, Md.

Don Grove Cemetery, Allegany

in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7421

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07411

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 13 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 709 Frederick Street				d. STREET ADDRESS 709 Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lorena Middle Ellen Last Hamilton				4. DATE OF DEATH Month July Day 8 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 2, 1876			
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Teeters				14. MOTHER'S MAIDEN NAME Hannah Monnett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mildred Houck Address 709 Frederick Street, Cumberland, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Uraemia							4 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis DUE TO							3 yrs		
(c) Arteriosclerosis							10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 1, 1961 to July 8, 1961 ; that (I) (we) last saw the deceased alive on July 8, 1961 and that death occurred at 4:20 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Clayton L. Swett M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/10/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		25a. RECEIVED BY REGISTRAR DATE JUL 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11270

CERTIFICATE OF DEATH

1931



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 50 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 17 Bellevue Street						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 17 Bellevue Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN ELMER HARE						4. DATE OF DEATH Month July Day 14 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 23, 1910		9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith's helper				10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Wilson Hare						14. MOTHER'S MAIDEN NAME Emma Barger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. J. E. Hare, 17 Bellevue St., Cumb., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) CORONARY SCLEROSIS (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. Month 19 Day 19 Year 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 14, 1961 DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/17/61		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		22d. LOCATION (City, town, or country) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Maryland						24a. REC'D BY REGISTRAR DATE JUL 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

100-100

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7423

07413

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>417 Central Avenue</u>				d. STREET ADDRESS <u>417 Central Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH JANE HARRIS</u>				4. DATE OF DEATH Month Day Year <u>July 8, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 25, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Chambermaid</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Grafton, West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert Harris</u>				14. MOTHER'S MAIDEN NAME <u>Louisa McDaniel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Miss Hattie Harris, 417 Central Ave., Cumb., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u>							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-3-1961</u> to <u>7-8-1961</u> , that (I) (we) last saw the deceased alive on <u>7-4-1961</u> , and that death occurred at <u>7-8-1961</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L Brings</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lewis Brings, M.D.</u>				22d. ADDRESS <u>57 Greene Street, Cumberland, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 11, 1961</u>		<u>Rose Hill Cemetery</u>		<u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

07413

CERTIFICATE OF DEATH

1152

(M)

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7424

07414

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 17 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 605 LEIPER STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RANDOLPH Middle B. Last HARTLEY		4. DATE OF DEATH Month JULY Day 19 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1897 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CARRIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RILEY HARTLEY		14. MOTHER'S MAIDEN NAME FRANCES LEIGHTY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 17 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1960 P.M. 7-9, 1961, that (I) (we) last saw the deceased alive on 7-19 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William P. James M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-22-61
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 N. CENTRE STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/22/61	23c. NAME OF CEMETERY OR CREMATORY Glendale Brethren Cem.	23d. LOCATION (City, town or county) (State) Flintstone, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 24 '61	25b. REGISTRAR'S SIGNATURE Charles E. James

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07415

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, Page 1, 2, and 3 of this certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 33 Beall Street				d. STREET ADDRESS 33 Beall Street			
3. NAME OF DECEASED (Type or print) Nan Jeffries				4. DATE OF DEATH July 6 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30th, 1881	9. AGE (In years last birthday) 79 yrs.	10. UNDER 1 YEAR Months 7 Days 6	11. IF UNDER 24 HRS. Hours 6 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Jabez Jeffries			
14. MOTHER'S MAIDEN NAME Jane Grose				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) None			
16. SOCIAL SECURITY NO. Miss Beulah Grose				17. INFORMANT Address 33 Beall St. Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Sudden DUE TO (c) Several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W.D. Mc Lane				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W.D. Mc Lane MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 167 E. Main 7-7-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE HEREOF 7-9-61		22c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park	
23. FUNERAL DIRECTOR L. P. Stuart				24a. REC'D BY REGISTRAR DATE JUL 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
22d. LOCATION (City, town, or county) Frostburg				22e. (State) Md.			

(M)

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Handwritten notes and stamps, including "MAY 1961" and "MAY 1962".

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7426

CERTIFICATE OF DEATH

Reg. Dist. No.

07416

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 Wilmont Ave.		d. STREET ADDRESS 117 Wilmont Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRED Middle WILLIAM Last JENKINS		4. DATE OF DEATH Month July Day 5 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER & OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY TAXI CO.	
11. BIRTHPLACE (State or foreign country) Terra Alta, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry A. Jenkins		14. MOTHER'S MAIDEN NAME Laura G. May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Martha Jenkins		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Cardiac Decompensation		INTERVAL BETWEEN ONSET AND DEATH yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 54 , to July 5 , 19 61 , that I lost saw the deceased alive on June 22 , 19 61 , and that death occurred at 12:10 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Md. DATE SIGNED 7/6/61			
ACTUAL SIGNATURE George M. Simons M.D.			
PHYSICIAN'S NAME (Type) George M. Simons M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/1961	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUL 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7427

CERTIFICATE OF DEATH

07417

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN TB <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>MINERAL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL KEYSER</u> d. STREET ADDRESS <u>85 X. 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLAY</u> Middle <u>Forrest</u> Last <u>KERNS</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>19 61</u>	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-24</u> 9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARION KERNS</u>		14. MOTHER'S MAIDEN NAME <u>GEORGE ALBERTON KERNS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		17. INFORMANT <u>CHART</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, with cerebral edema & pericarditis</u> DUE TO <u>445x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Malignant Hypertension with Nephrosclerosis</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 years (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; generalized arteriosclerosis; congenital abs. l. kidney</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 28th, 1961 to July 11th, 1961, that (I) (we) last saw the deceased alive on July 10th, 1961, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Wyand F. Doerner, M.D.</u> M.D.		22b. DATE SIGNED <u>7-12-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, M.D.</u>		22d. ADDRESS <u>414 N. Mechanic Street, Cumberland</u> <u>Westernport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/11/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Westernport Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>E.S. B...</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. H...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

7428

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07418

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 25 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 50 1/2 Ormond Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Henry Knepp		4. DATE OF DEATH July 24th, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11th, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR: Months 7 Days 24 Hours 11 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Work W.Md.R.R.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Theodore Knepp	
14. MOTHER'S MAIDEN NAME Katherine Mathias		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 712-14-1613		17. INFORMANT John Knepp, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastasis - carcinoma DUE TO (b) Recurrent carcinoma stomach Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. 5-25 p.m. 7-28		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-25-1961 to 7-28-1961 , that (I) (we) last saw the deceased alive on 7-1-1961 , and that death occurred 5 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Earl R. Paul		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Earl R. Paul,		22d. ADDRESS 36 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-61	
23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial (Gardens)		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Hurst		25a. REC'D BY REGISTRAR DATE JUL 27 '61	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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Handwritten notes and signatures at the bottom of the page, including the name "H. B. ...".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07419**

7429

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN Years 02 Cumberland,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital--DOA				d. STREET ADDRESS 1 304 Independence St.			
3. NAME OF DECEASED (Type or print) First ROBERT Middle WILLIAM Last KNIGHT				4. DATE OF DEATH Month July Day 27 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1911	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 27 Hours 1961	IF UNDER 24 HRS. Hours 1961 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Sport shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Howard Knight				14. MOTHER'S MAIDEN NAME Matilda Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Louis H. Knight 318 Fayette St. Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 27, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/31/61		H. Peter & Paul Cem.		Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.				24a. REC'D BY REGISTRAR DATE JUL 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
Last Name		First Name		Middle Name		Initials		Month		Day	
Street		City		State		Zip		County		Municipality	
Occupation		Education		Marital Status		Religion		Social Security Number		Maiden Name	
Cause of Death		Manner of Death		Contributing Factors		Medical History		Previous Illnesses		Previous Injuries	
Time of Death		Place of Death		Witnesses		Signature of Examiner		Signature of Coroner		Signature of Physician	
Date of Autopsy		Place of Autopsy		Autopsy Findings		Toxicology		Microscopic Examination		Radiology	
Date of Burial		Place of Burial		Burial Certificate		Burial Permits		Burial Fees		Burial Expenses	

CERTIFICATE OF DEATH

Reg. Dist. No. **07420**

7430

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 37				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland			
3. NAME OF DECEASED (Type or print) AGNES First Middle Last M. LANGAN				4. DATE OF DEATH Month 7 Day 27 Year 1961			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-1887	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Shaft, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Monahan				14. MOTHER'S MAIDEN NAME Elizabeth Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Angela McElwee, Box 37, Midland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Peritonitis 572.1 DUE TO (b) Ruptured diverticulum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic diverticulitis				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive heart failure, arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar. , 19 61 , to July , 19 61 , that I last saw the deceased alive on May , 19 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L.R. Miles Jr.				DATE SIGNED 7-29-61			
PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.				ADDRESS Sonoma, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/31/61		St. Michaels Cemetery		Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HAFFER FUNERAL HOME				24a. REC'D BY REGISTRAR AUG 1 '61			
Paul H. Mortimer				24b. REGISTRAR'S SIGNATURE William S. Kraw			
23 E. MAIN, FROSTBURG, MD.							

Figure 1

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07421

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital (DOA)</u>		d. STREET ADDRESS <u>Homewood Addition Rt. #1 Cumb. Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Weseph</u> Last <u>Maravia Jr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1927</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Attendant.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Ber. Bush WVa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Maravia</u>		14. MOTHER'S MAIDEN NAME <u>Grace Ford.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 11</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Ella M. Sheally.</u>		Address <u>Cumberland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBDURAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SKULL FRACTURE, CONTUSION OF BRAIN</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? * YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Unknown</u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>1961</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u>Cumberland, Alleg. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/30/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thomas WVa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 1 '61</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

17731

M

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 38		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
Name of Deceased: <u>John J. [illegible]</u>		Age: <u>45</u>	
Sex: <u>Male</u>		Race: <u>White</u>	
Date of Death: <u>Jan. 2, 1957</u>		Place of Death: <u>Home</u>	
Cause of Death: <u>Heart Disease</u>		Manner of Death: <u>Natural</u>	
Signature of Medical Examiner: <u>[illegible]</u>		Signature of Coroner: <u>[illegible]</u>	
Date: <u>Jan. 3, 1957</u>		City: <u>Baltimore</u>	
County: <u>[illegible]</u>		State: <u>Md.</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07422

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gilmore R-F-D-# 1 c. LENGTH OF STAY IN b Gilmore R-F-D # 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore R-F-D # 1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JAMES Middle ROBERT Last McCLUNG			4. DATE OF DEATH Month July Day 12 Year 1961		
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/4/1957 9. AGE (In years last birthday) 3 yrs. 7 months 8 days IF UNDER 1 YEAR IF UNDER 24 HRS. Hours 7 Min. 8			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Frostburg, MD. 12. CITIZEN OF WHAT COUNTRY? U-S-A		
13. FATHER'S NAME Everrett McClung 14. MOTHER'S MAIDEN NAME Alma Gallagher			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Alma McClung Gilmore, MD Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charring Burn of Entire Body (b) Asphyxiation (c) 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Sudden "		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned to death in fire in home		
20c. TIME OF INJURY Month, Day, Year 10:15 p.m. July 12 1961			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home 20f. (City or town) Gilmore (County) Allegany (State) MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE WOMcLane MD EXAMINER'S NAME (Type) WOMcLane MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ant Address (Street, city, town, or county) Frostburg Allegany MD		
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 7/16/1961		22c. NAME OF CEMETERY OR CREMATORY Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, MD.		23. FUNERAL DIRECTOR GEORGE EICHHORN ADDRESS LONACONING, MD.			
24a. REC'D BY REGISTRAR DATE JUL 17 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

MEDICAL CERTIFICATION

THE STATE
HEALTH DEPT.
(M)

03823

1133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Allegany
Lawrence
11-1-1911

NAME WITH
RESIDENCE
11-1-1911

PROSECUTOR, IN
THE CASE OF

Chambers v. State
W. Chambers

James W. Chambers
11-1-1911

W. Chambers
11-1-1911

11-1-1911
11-1-1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07423**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore R-F-D # 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore- R-F-D- # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First LINDA Middle K Last McCLUNG		4. DATE OF DEATH Month July Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/1956
9. AGE (In years last birthday) 4 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Everrett McClung		14. MOTHER'S MAIDEN NAME Alma Gallagher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Alma McClung, Gilmore, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choking Burn of Entire Body 916.0 DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) " (c) "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned to death in fire in home	
20c. TIME OF INJURY Month, Day, Year 10:15 p.m. July 12 1961		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Home		20f. (City or town) (County) (State) Gilmore Allegany MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.D. Mc Lane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W.D. Mc Lane MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER Frostburg Allegany MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/1961	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	
24a. REC'D BY REGISTRAR JUL 17 '61		24b. REGISTRAR'S SIGNATURE Clifford S. Hanna	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR THE
RECORD

RECEIVED
FEB 11 1964
BOND

07123

1963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BANGOR

NAME: *John J. Smith* SEX: *M* AGE: *65* RACE: *W*

DATE OF DEATH: *1-15-64* PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Myocardial Infarction*

IMMEDIATE CAUSE: *Coronary Atherosclerosis*

UNDERLYING CAUSE: *Essential Hypertension*

OTHER CAUSES: *None*

DEATH CERTIFICATE NO. *12345*

DATE OF ISSUE: *1-15-64*

SIGNATURE OF EXAMINER: *Dr. J. H. Jones*

DATE OF SIGNATURE: *1-15-64*

PLACE OF SIGNATURE: *Bangor, Maine*

OFFICE OF THE MEDICAL EXAMINER

STATE OF MAINE

BANGOR

1-15-64

12345

John J. Smith

Myocardial Infarction

Coronary Atherosclerosis

Essential Hypertension

None

Dr. J. H. Jones

1-15-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07424

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore R-F-D # 1 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore R-F-D # 1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAMELA M. McCLUNG			4. DATE OF DEATH July 12, 1961				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 8/4/1960			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 10 8 19 IF UNDER 1 YEAR: Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Everrett McClung			14. MOTHER'S MAIDEN NAME Alma Gallagher				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Alma McClung Gilmore, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charring Burn of Entire Body DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Burned to death in fire in home					
20c. TIME OF INJURY Month, Day, Year 10:15 p.m. July 12 1961		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Gilmore		20g. (County) Allegany		20h. (State) MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE WOMcLane		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-13-61			
EXAMINER'S NAME (Type) WOMcLane MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Frostburg Alleg MD			
22a. BURIAL, CREMATION, or other disposition (See city) Burial		22b. DATE THEREOF 7/16/1961		22c. NAME OF CEMETERY OR CREMATORY Memorial Park			
22d. LOCATION (City, town, or country) (State) Frostburg, MD.		24a. REC'D BY REGISTRAR JUL 17 '61					
23. FUNERAL DIRECTOR GEORGE EICHHORN		ADDRESS LONACONING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1000308XV3

54-21-10010

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THE BOUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7435 CERTIFICATE OF DEATH 07425

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 43yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 131 Polk Street		d. STREET ADDRESS 131 Polk Street	
3. NAME OF DECEASED (Type or print) John L. McGeady		4. DATE OF DEATH July 14, 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1990
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John J. McGeady	
14. MOTHER'S MAIDEN NAME Julia Cavanaugh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes War I	
16. SOCIAL SECURITY NO. 214-32-3537		17. INFORMANT Lucille McGeady 131 Polk St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cordo-vascular disease DUE TO (c) 6 yrs.		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February 12, 1958 to July 14, 1961 , that (I) (we) last saw the deceased alive on July 12, 1961 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wylie M. Faw Jr.		22b. DATE SIGNED July 16, 1961	
22c. PHYSICIAN'S NAME (Type or print) Wylie M. Faw Jr.		22d. ADDRESS 122 S. Centre St. Cumberland, Md.	
23a. BURIAL, CREMATION, or OTHER DISPOSAL (Specify) Burial		23b. DATE THEREOF 7-17-61	
23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR JUL 18 61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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Allegany

Wayland

Allegany

Cambridge

Cambridge

Cambridge

121 Park Street

121 Park Street

John B.

Agency

July 19

June 30, 1890

John J. Kennedy

John J. Kennedy

219-2-2527 Lucille Kennedy 121 Park St.

Company & Co.
Office, 121 Park Street, Boston, Mass.

January 27, 1914

John J. Kennedy

John J. Kennedy

John J. Kennedy

John J. Kennedy

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7436

CERTIFICATE OF DEATH

07426

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VINDEXT</u>			
c. LENGTH OF STAY IN 1b <u>15MIN.</u>				d. STREET ADDRESS <u>11 X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE MAE McROBIE</u>				4. DATE OF DEATH Month Day Year <u>JULY 9 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM PUEBINBARGER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA F. LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>NEWTON McROBIE</u>		Address <u>VINDEXT, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident - embolus</u> 420 J DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular fibrillation</u> ? (c) <u>Hypertension; Coronary arteriosclerosis; myocardial fibrosis; left ventricular hypertrophy</u> ?							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1958</u> to <u>July 9, 1961</u> that (I) (we) last saw the deceased alive on <u>July 5, 1961</u> , and that death occurred at <u>7:20 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel M. Jacobson</u>				22b. DATE SIGNED <u>7/9/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M. D.</u>				22d. ADDRESS <u>50 Pershing St. Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KALBAUGH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ELK GARDEN, W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>MILDRED SHARPLESS</u>				25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7437											
CERTIFICATE OF DEATH											
07427											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg				d. STREET ADDRESS 1 27 Charles Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DANIEL B. MILLER						4. DATE OF DEATH Month 7th Day 25 Year 19 61.					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/5/1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 7 Days 25 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines				11. BIRTHPLACE (County & State, or foreign country) Zihlman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George C. Miller						14. MOTHER'S MAIDEN NAME Eliza Stevens					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)						17. INFORMANT Address Frostburg, Md. Mrs. Hazel K. Miller, 27 Charles St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Coronary Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from July 23, 1961 , to July 25, 1961 , that (I) (we) last saw the deceased alive on July 23, 1961 , and that death occurred at 11:40 PM , from the causes and on the date stated above. 22a. SIGNATURE Wm C Lane M.D. 22b. DATE SIGNED July 26 1961 22c. PHYSICIAN'S NAME (Type) Wm C Lane M.D. 22d. ADDRESS Frostburg Md 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7-28-61 23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md. 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE HAFFER FUNERAL HOME Beulah N. Montecarlo 25a. REC'D BY REGISTRAR SUL 31 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7438

07428

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in lb 16da, 8hr., 6min.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 109 S. LEE ST.	
3. NAME OF DECEASED (Type or print) First WINIFRED Middle VIRGINIA Last MITNICK		4. DATE OF DEATH Month 7 Day 7 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-14
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME WILLIAM JACKSON TRASK		14. MOTHER'S MAIDEN NAME META WOLFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastatic, with origin in Right Ovary (Adenocarcinoma) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., the causes and on the date stated above.			
22a. SIGNATURE Carlton Brinsfield		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD, M.D.		22d. ADDRESS 232 BALTIMORE AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/10/61	23c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cemetery	23d. LOCATION (City, town or county) (State) Cumberland Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR JUL 12 '61	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7439

CERTIFICATE OF DEATH

07429

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Road, Cumberland				c. LENGTH OF STAY IN 1b 40 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley Road				d. STREET ADDRESS Valley Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JUDIE Middle NORTH Last CRAFT				4. DATE OF DEATH Month July Day 8 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1880	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Purcell, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Cavender				14. MOTHER'S MAIDEN NAME Amy Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Walter H. Northcraft, Valley Rd., Cumb., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) gpc				INTERVAL BETWEEN ONSET AND DEATH gpc			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 1961 to July 8 1961 , that (I) (we) last saw the deceased alive on July 8 1961 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE George M. Simons				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/10/61	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M.D.				22d. ADDRESS Algonquin Hotel, Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/61		23c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cem.		23d. LOCATION (City, town, or county) (State) Artemas, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE JUL 13 '61		25b. REGISTRAR'S SIGNATURE William S. Evans	

MEDICAL CERTIFICATION

05253

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7440
CERTIFICATE OF DEATH
07430

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 70yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 1105 1/2 Virginia Ave	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1105 1/2 Virginia				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John H. Orndoff				4. DATE OF DEATH Month July Day 30 Year 19 61			
5. SEX F.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1869	
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Millwright		10b. KIND OF BUSINESS OR INDUSTRY Tin Plate Mill		11. BIRTHPLACE (County & State, or foreign country) Oldfield, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Orndoff				14. MOTHER'S MAIDEN NAME Sarah M. Lee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-0864		17. INFORMANT Mamie Orndoff 1105 1/2 Virginia Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Myocarditis - Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coroniosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs 20 yrs				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 61 to July 30 , 19 61 ; that (I) (we) last saw the deceased alive on July 28 , 19 61 , and that death occurred 9:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett				M.D. Clay E. Durrett		22b. DATE SIGNED July 30, 1961	
22c. PHYSICIAN'S NAME (Type) Clay E. Durrett				22d. ADDRESS 236 Virginia Ave Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-61		23c. NAME OF CEMETERY OR CREMATORY Sabury Cemetery		23d. LOCATION (City, town or county) (State) Asbury, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE AUG 4 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kins	

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1105 Virginia Ave

John F. Chamberland

July

Nov. 11, 1881

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Retired millwright the place the Chamberland, N.V.

Henry Chamberland

Barth N. Lee

50-10-084

Chamberland 1105 Virginia Ave.

Chamberland
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Clay F. Barrett

1105 Virginia Ave Chamberland, N.V.

Barth

Barth Chamberland

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Chamberland, N.V.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b X		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Florida Way				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle V. Last O'Rourke		4. DATE OF DEATH Month July Day 1 Year 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 10, 1884		9. AGE (In years last birthday) 77 1/2 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Peter O'Rourke				14. MOTHER'S MAIDEN NAME Mary Bradley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Miss. Bernadetten O'Rourke		Address Lonaconing			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial ischemia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Profound Anemia; Malnutrition; intestinal obstruction - cause unknown								INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Profound Anemia; Malnutrition; intestinal obstruction - cause unknown									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Lonaconing		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1956 to July 1, 1961 , that (I) (we) lost saw the deceased alive on June 30, 1961 , and that death occurred at 3 AM , from the causes and on the date stated above.									
22a. SIGNATURE L.R. Miles, Jr. M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.				22d. ADDRESS LONACONING MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/61		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE JUL 5 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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CERTIFICATE OF DEATH
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1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 30 Race Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dora E. Pittman				4. DATE OF DEATH Month July Day 30 Year 1961			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		IF UNDER 24 HRS. Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Schad				14. MOTHER'S MAIDEN NAME Lydia Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Samuel Scaturro 30 Race St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Artery & Myocardial Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery & Myocardial Disease DUE TO Coronary Artery & Myocardial Disease (c) Coronary Artery & Myocardial Disease				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10-2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/17/60 19..... to 7/26/61 19....., that (I) (we) last saw the deceased alive on 7/29/61 19....., and that death occurred at 5:30 19....., from the causes and on the date stated above.							
22a. SIGNATURE Richard J. Williams				22b. DATE SIGNED 8/1/61		22c. PHYSICIAN'S NAME (Type or print) Richard J. Williams	
22d. ADDRESS 122 S. Centre St. Cumberland, Md.				22e. REC'D BY REGISTRAR DATE AUG 4 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Hume	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24b. ADDRESS Cumberland, Md.		24c. REC'D BY REGISTRAR DATE AUG 4 '61	



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D.O. Memorial Hospital

July 20, 1943

William

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John

May 23, 1943

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Washington, D.C.

Germany

Germany

Lydia Miller

Henry Miller

Mr. Samuel Jackson 30 Race St.

Home

No

James F. Campbell
James F. Campbell

James F. Campbell

W. H. Miller

W. H. Miller

130 E. Center St., Chamberlain, S.D.

Thomas J. Williams

Wilkes-Barre Hospital, Wilkes-Barre, Pa.

Barrel 5-2-41

James F. Campbell, Chamberlain, S.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7443

07433

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN 1b <u>12 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SACRED HEART Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>19 CAMP GROUND ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARA Catherine POISAL</u>		4. DATE OF DEATH <u>JULY 8, 19 61</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1901</u> 9. AGE (In years last birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>MARTIN P. MARTZ</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MARTZ Marley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>CHART</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes mellitus</u> (c) <u>Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> INTERVAL BETWEEN ONSET AND DEATH <u>Diabetes</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/8 1961</u> to <u>7/8 1961</u> , that (I) (we) last saw the deceased alive on <u>7/8 1961</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>S. G. Weisman</u>		22b. DATE SIGNED <u>7/8 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>S.G. Weisman, M.D.</u>		22d. ADDRESS <u>59 Green Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul's Cem</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. L. S. Hines</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and delay is necessary, place a check in the box for "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Near Luke, Maryland		c. LENGTH OF STAY IN lb Minutes		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
3. NAME OF DECEASED (Type or print) Guy		First Donald		Middle Reckart		Last Reckart		4. DATE OF DEATH Month July	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1928		9. AGE (In years last birthday) 33 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Warley Reckart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 2		17. INFORMANT Junior Reckart		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SKULL FRACTURE DUE TO (c) TRUCK ACCIDENT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) RUN-AWAY TRACTOR TRAILER CRASH		20c. TIME OF INJURY Month, Day, Year 8:00 p.m. July 15 1961		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 135 near	
20f. (City or town) Bloomington, Garrett, Md.		20g. (County) Garrett		20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF July 19, 1961		22c. NAME OF CEMETERY OR CREMATORY Cuzzard, Cem.		22d. LOCATION (City, town, or country) Cuzzard		22e. (State) W. Va.		23. FUNERAL DIRECTOR C.S. Boal	
23. ADDRESS Westernport, Maryland		24a. REC'D BY REGISTRAR Jul 19 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Travis		24c. DATE Jul 19 '61		24d. TIME 10:00	

M

33

Handwritten signature

6252

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7445

07435

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Millard C. Reed				4. DATE OF DEATH July 15, 1961 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1906		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cenaese Employee		10b. KIND OF BUSINESS OR INDUSTRY Textiles		11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles T. Reed				14. MOTHER'S MAIDEN NAME Myrtle Flægle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-4408		17. INFORMANT Mrs. M.C. Reed, Ellerslie, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary Thrombosis Acute. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Heart Disease with Coronary Insufficiency DUE TO (c) Acute myocardial infarction, antero septal - Jan. 1961						INTERVAL BETWEEN ONSET AND DEATH approx. 1/2 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 3/25 1951, to July 15 1961, that (1) (we) last saw the deceased alive on July 12 1961, and that death occurred at 6:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE John A. Topper M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-15-61	
22c. PHYSICIAN'S NAME (Type) John A. Topper M.D.				22d. ADDRESS Hyndman Pa.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Cooks Mills		23d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Seigler ADDRESS Hyndman, Pa.				25a. REC'D BY REGISTRAR JUL 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

1943

Central Post Office

07533

Allegany

Marshall

Allegany

Eligible

File

Eligible

William C. Reed

May 15, 1941

White

Dec. 9, 1906

33

Census Bureau, Textiles

W. C. Reed, Jr.

USA

Lydia Elsie

Charles T. Reed

WV-10-408 Mrs. W. C. Reed, Wheeling, W. Va.

No

Reed, W. C.

May 15, 1941 Census Bureau

Reed

Reed, W. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7446

07436

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. d. STREET ADDRESS 714 GLENMORE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIOLA Middle H. Last RICE		4. DATE OF DEATH Month JULY Day 10 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ownhome		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years less birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. HOFF		14. MOTHER'S MAIDEN NAME ANNA M. BAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (c) Myocardial Infarction DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1961 to July 1961 , that (I) (we) last saw the deceased alive on July 10 1961 , and that death occurred at 4:15 P.M. the causes and on the date stated above.			
22a. SIGNATURE DR. OVERTON G HIMMELWRIGHT		22b. DATE SIGNED 7/11/61	
22c. PHYSICIAN'S NAME (Type) DR. OVERTON G HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-13-61	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park Cumberland, Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

(I)

ALLIANCE

CUMBERLAND, MD.

MEMORIAL HOSPITAL
GENERAL & SURGICAL WING

VIOLA

FEMALE WHITE

George W. Holt

George W. Holt

K

H.

RICE

3-23-1906

CUMBERLAND, MD.

WILLIAM M. BAKER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

ALLIANCE

CUMBERLAND

CUMBERLAND, MD.

711 GLENVIEW ST.

JULY

10

31

07407

1946

DR. OVERTON & HILFELMIGHT

193 VIRGINIA AVE., CUMBERLAND, MD.

7-15-51

HILFELMIGHT HARTLEY PARK CUMBERLAND, MD.

James W. Overton & Hilfelmigh, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7447 CERTIFICATE OF DEATH 07437											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b I Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE W.VA. b. COUNTY Morgan c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PAW PAW, W.VA d. STREET ADDRESS c/o Postmaster e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MARY Middle Katherine Last ROBEY						4. DATE OF DEATH Month JULY Day 6 Year 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Paw Paw, W. Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Kline						14. MOTHER'S MAIDEN NAME Sarah Dolland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4 43X IMMEDIATE CAUSE (a) Hypertensive arterio-sclerotic (acute circulatory collapse) vascular disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Extensive carcinoma operatively removed 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Since 5-19-58											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 5-19-58 to 7-6-61 that (I) last saw the deceased alive on 7-3-61 and that death occurred at 7:45 P.M. on the causes and on the date stated above.											
22a. SIGNATURE W. F. Williams M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 7-7-61		
22c. PHYSICIAN'S NAME (Type) DR W. F. WILLIAMS						22d. ADDRESS 122 S CENTRE ST., CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/9/61		23c. NAME OF CEMETERY OR CREMATORY Camp Hill Cem.			23d. LOCATION (City, town or county) (State) Paw Paw, (Morgan) W. Va.				
24. FUNERAL DIRECTOR'S SIGNATURE Parks-Johnson Co., Berkeley Springs, W. Va.						ADDRESS JUL 10 '61			25a. REC'D BY REGISTRAR Arthur S. Finner		
						25b. REGISTRAR'S SIGNATURE					

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07497

ALLEGANY

ALLEGANY

UNIVERSITY

UNIVERSITY

I DOX

MEMORIAL HOSPITAL
MEMORIAL & WILKIN AVE.

MEMORIAL HOSPITAL

WBY

WBY

ROBBY

JULY

FEMALE WHITE

June 20, 1904

Housewife

New York, N. Y.

Charles Williams

Charles Williams

MEMORIAL HOSPITAL, CUMBERLAND, O.

10

*Appointed to the position of
Surgeon (General) (Cumberland, Ohio)
2-14-05*

Dr. W. F. Williams

2-19-03 7-5-01

Dr. W. F. Williams

152 S CENTRE ST., CUMBERLAND, O.

DR. W. F. WILLIAMS

Arrival 7/3/01 Camp Hill Can. New York, (Grover), N. Y.

Parker-Johnson Co., Veterinary Supplies, N. Y. 1001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7448
CERTIFICATE OF DEATH
07438

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY in 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 975 Williams Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 975 Williams Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary F. Robinette		4. DATE OF DEATH July 21, 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1868
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hanson Bucy		14. MOTHER'S MAIDEN NAME Mary Dunn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Riley Payne		Address 975 Williams Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 19, 1961 to July 19, 1961 , that (I) (we) last saw the deceased alive on July 19, 1961 , and that death occurred at 12:30 from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clay E. Durrett		22d. ADDRESS 236 Virginia Ave. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-23-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.	23d. LOCATION (City, town or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR JUL 26 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

VR A15 (4)
15M 9/60

(M)

7448

07438

Allegany

Chamberlain

Allegheny

Chamberlain

Allegheny

975 Williams Road

975 Williams Road

July 21, 1968

July 21, 1968

BI

April 11, 1968

General Honorable

General Honorable

USA

Hanson Buck

Hanson Buck

No.

U.S. Highways Rys Williams Road

U.S. Highways

U.S. Highways

U.S. Highways

123

X

300 Virginia Ave. Chamberlain, N.D.

Clay E. Bennett

Chamberlain, N.D.

Chamberlain, N.D.

7-22-61

April 1

James E. Bennett

Chamberlain, N.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

7449

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07439

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN lb 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. d. STREET ADDRESS 403 ARCH ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ORIE V. ROYCE		4. DATE OF DEATH Month JULY Day 4 Year 1961				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 26, 1898	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Track Foreman Railroad		10b. KIND OF BUSINESS OR INDUSTRY OKONOKO, W. VA		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM H. ROYCE		14. MOTHER'S MAIDEN NAME ANNA E. WHITACRE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-09-7017		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Chronic Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Allegany Md.		20f. City or town (County) (State) Allegany Md.
21. I certify that (I) (this hospital) attended the deceased from 6/22/61 , 19....., to 7/4/61 , 19....., that (I) (we) last saw the deceased alive on 7/3/61 , 19....., and that death occurred at 8:40 P.M. the cause and on the date stated above.						
22a. SIGNATURE DR. RICHARD J. WILLIAMS		22b. DATE SIGNED 7/5/61		22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS		
22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-7-1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS —		25a. REC'D BY REGISTRAR JUL 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

03488

12



ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

11 DAYS

CUMBERLAND, MD.

HOG ARCH ST.

MEMORIAL HOSPITAL
HETTERAL & WARRICK AVE.

JULY 1 1901

ROYCE

V.

ORIE

AUG 26, 1898

MALE WHITE

U.S.A.

CRONKOD, N.Y.

Retired Truck Foreman Baltimore

ANN E. WHITBRE

WILLIAM H. ROYCE



706-08-7017 MEMORIAL HOSPITAL, CUMBERLAND, MD.

NO

James E. Heston
James E. Heston

C/22/14
5/14

James E. Heston

122 S. CENTRE ST., CUMBERLAND, MD.

DR. HOWARD J. WILLIAMS

Memorial Hospital, Cumberland, Md.

11-7-1901

11-7-1901

James E. Heston, Cumberland, Md.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07440

7450

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bedford Valley</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>Bedford RFD #3</u>	
3. NAME OF DECEASED (Type or print) First <u>Wilma</u> Middle <u>Glene</u> Last <u>Ruby</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 24 1939</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Lockard</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Fuller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Memorial Hosp. Cumb.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AORTIC VALVE STENOSIS</u> 751-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ENDOCARDIAL FIBROELASTOSIS</u> DUE TO (c) <u>CONGENITAL</u> INTERVAL BETWEEN ONSET AND DEATH YEARS CONGENITAL			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 11, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/14/61</u>	<u>Restlawn Cem.</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stern Inc. Cumb. Md</u>		24. REC'D BY REGISTRAR DATE <u>JUL 13 61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07441

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 439 RACE ST.	
3. NAME OF DECEASED (Type or print) JAMES ARTHUR SAVAGE		4. DATE OF DEATH Month JULY Day 24 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2, 1899
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY CHURCH	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SHERMAN G. SAVAGE		14. MOTHER'S MAIDEN NAME MARTHA CROSS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 194-01-4268	
17. INFORMANT Address Mrs. James Savage 439 Race St. Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, left pleura (mesoendothelioma) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary arteriosclerosis; myocardial fibrosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 17, 1961 to July 24, 1961 , that (I) (we) last saw the deceased alive on July 23, 1961 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Samuel M. Jacobson		22b. DATE SIGNED 7/24/61	
22c. PHYSICIAN'S NAME SAMUEL M. JACOBSON, M.D.		22d. ADDRESS PERSHING ST., CUMBERLAND, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/26/1961	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town or county) (State) McHenry, Md.
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		25a. REC'D BY REGISTRAR DATE JUL 28 '61	
ADDRESS Oakland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Finney	

03141

STATE OF OHIO

1931



ALIAS

WARRANT

BY DAYS

10 DAYS

PAID BY THE STATE

100.00

JULY 2, 1931

RECEIVED

ARTHUR

100.00

100.00

JULY 2, 1931

PAID

100.00

100.00

RECEIVED

CHURCH

100.00

RECEIVED

RECEIVED

100-1-1000

10

CHURCH

100-1-1000

100-1-1000

100-1-1000

100-1-1000

100-1-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7452

Item 8 Film G291 7/27/61 iwk

CERTIFICATE OF DEATH

07442

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN lb 29 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MD. d. STREET ADDRESS 6 ELDER ST., CUMBERLAND, MD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIA MARGUERITE SHAFER		4. DATE OF DEATH Month JULY Day 17 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1889 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) CHAMBERSBURG, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES P SHAFER		14. MOTHER'S MAIDEN NAME VIRGINIA ELLA BEDFORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Acute Coronary Occlusion (c) Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 17, 1961 to July 19, 1961 , that (I) (we) last saw the deceased alive on July 17, 1961 , and that death occurred at 12:50 P.M. on the cause and on the date stated above.			
22a. SIGNATURE Dr. Overton G. Himmelwright M.D.		22b. DATE SIGNED 7/19/61	
22c. PHYSICIAN'S NAME (Type) DR. OVERTON G HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/20/61	23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	23d. LOCATION (City, town or county) (State) CUMBERLAND MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE RUTH E. SILCOX CUMBERLAND MARYLAND		25a. REC'D BY REGISTRAR JUL 24 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Fraw	

18

107425

1122

ALLEGANY

WARRIAND

ALLEGANY

CUMBERLAND, MD.

29 DAYS

CUMBERLAND, MD.

EIDER ST., CUMBERLAND, MD.

MEMORIAL HOSPITAL
133 VIRGINIA AVE.

19 JULY 19

SHAFER

WAGNERITE

JULIA

FEMALE WHITE

2-21-1900

CHESBROUGH, PENNA. U.S.A.

AT HOME

CHESBROUGH

VIRGINIA CLIA BEDFORD

CHARLES F. SHAFER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

Handwritten notes:
1900
1900
1900

Handwritten notes and signatures:
1900
1900
1900
1900

DR. CARTON & HILBERT 133 VIRGINIA AVE., CUMBERLAND, MD.

WARRIAND

WARRIAND

WARRIAND

WARRIAND

WARRIAND

WARRIAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7453

CERTIFICATE OF DEATH

07443

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/30/61	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS Cumberland	
3. NAME OF DECEASED (Type or print) First Wilbur Middle Pierce Last Shank		4. DATE OF DEATH Month July Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1881
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80	IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Electrician		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Phillip Shank		14. MOTHER'S MAIDEN NAME Elizabeth R. Heinze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. P.O.Box 599	
17. INFORMANT Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concomitant Thrombosis DUE TO (b) arterio sclerosis - & Hypertension DUE TO (c) lying cause lost. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/30/61 to 7/22/61 , that (I) (we) last saw the deceased alive on 7/22/61 at 8:45 P.M. , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 7/24/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25, 1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hofer		25a. REC'D BY REGISTRAR Arthur L. Hanes	
ADDRESS Cumberland, Md.		DATE JUL 27 '61	

1953

COMMITTEE OF CLERKS

1953

Allegany

Allegany

Allegany

Cambridge

8/30/51

Cambridge

Allegany County, Maryland

Winton

Winton

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Winton: Winton

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

7454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07444

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE W.VA.				b. COUNTY HARDY			
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KESSEL, W.VA.				c. LENGTH OF STAY IN lb 14 Hrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kessel, West Virginia			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital, Cumberland, Md.				d. STREET ADDRESS 85X-3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARNO C. SIMMONS				4. DATE OF DEATH July 31 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1913		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) W.Va.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Sanford, Simmons				14. MOTHER'S MAIDEN NAME WAYDE PRATT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. 236-12-9392				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				LOBAR PNEUMONIA, BILATERAL				INTERVAL BETWEEN ONSET AND DEATH 3-4 Days			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Newhouse Cemetery		22d. LOCATION (City, town, or country) (State) Rig. West Va.			
23. FUNERAL DIRECTOR Earl B. Horvath				ADDRESS Horvath F. Home, Maryland				24a. REC'D BY REGISTRAR DATE AUG 4 '61			
								24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7455

CERTIFICATE OF DEATH

07445

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/3/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 207 Offutt Street	
3. NAME OF DECEASED (Type or print) First Viola Middle Virginia Last Slider		4. DATE OF DEATH Month July Day 23 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 23 Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jessie P. Davis		14. MOTHER'S MAIDEN NAME Jeanette Jeffries	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, etc., degenerative 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/3/60 19____, to 7/23/61 19____, that (I) (we) last saw the deceased alive on 7/22/61 19____, and that death occurred at ____ M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 7/24/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene Street, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-61	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DATE JUL 27 '61	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

(M)

(I)

1888

CERTIFICATE OF DEATH

07445

Allegheny

Allegheny

Allegheny

Allegheny

9/3/80

Allegheny

Allegheny County Jail

Allegheny County Jail

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

CENTRAL STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7456
CERTIFICATE OF DEATH

07446

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 2 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 41 SOUTH STREET	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle V. Last SPEARS				4. DATE OF DEATH Month JULY Day 7, Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 21, 1889	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Oownhome		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE KORNS				14. MOTHER'S MAIDEN NAME ELIZABETH CROUTERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-1319		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rt breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) — DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 177 -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Hour — e.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Alleg Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/2/61 , 19 61 , to 7/7/61 , 19 61 , that (I) (we) last saw the deceased alive on 7/7/61 , 19 61 , and that death occurred at 8:45 AM on the causes and on the date stated above.							
22. SIGNATURE DR. R. J. WILLIAMS				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/12/61	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James E. Scarpelli Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JUL 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

(M)

ALLEGANY

MARYLAND

ALLEGANY

2 DAYS

CUMBERLAND

31 SOUTH STREET

MEMORIAL HOSPITAL
MEMORIAL & MARSHALL AVENUES

ELIZABETH V.

SPRARS

JULY

JANUARY 21, 1959

WHITE FEMALE

CUMBERLAND, MD.

CUMBERLAND

HOOD

ELIZABETH CROWTHER

GEORGE KORN

31-18-101 - MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. R. J. WILLIAMS

122 S. CENTRE ST., CUMBERLAND, MD.

Burial - 7-10-61 Rose Hill Cem.

CUMBERLAND, MD.

James R. Gortner III Cumberland, Md.

MD.

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FOR STATE
HEALTH DEPT.
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VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
7457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07447										
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			d. STREET ADDRESS 416 Park St.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 416 Park St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph G. Stierstorfer					4. DATE OF DEATH Month July Day 6 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1895		9. AGE (In years last birthday) 65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) New York, N. Y.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Stierstorfer					14. MOTHER'S MAIDEN NAME Mary Hoffman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War I					16. SOCIAL SECURITY NO. 220-03-7715					
					17. INFORMANT Address Mrs. Wilson Smith, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH SUDDEN --U--		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Benedict Skitarelic M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 6, 1961					
					Address (Street, city, town, or county) Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 7-10-1961		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery Cumberland, Md.			22d. LOCATION (City, town, or county) _____ (State) _____		
23. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					ADDRESS _____		24a. REC'D BY REGISTRAR DATE JUL 11 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7458

07448

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bealls Lane		d. STREET ADDRESS Bealls Lane	
3. NAME OF DECEASED (Type or print) Harry Teter		4. DATE OF DEATH July 7th, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7th, 1903
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist-Self		9b. AGE (In years last birthday) 58 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Dental		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dorwin B. Teter (Employed)	
14. MOTHER'S MAIDEN NAME Mary Virginia Dennison		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-38-6583		17. INFORMANT Mrs. Louise B. Teter, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 5 yrs? 8 to 10 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Hour X e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	20f. (City or town) X (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/6 1961 to 7/7 1961 , that (I) (we) last saw the deceased alive on 7/7 1961 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein, M.D.		22b. DATE SIGNED 7/7/61	
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein, "		22d. ADDRESS 48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-10-61	23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery	23d. LOCATION (City, town or county) (State) Keyser, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Dierst		25a. REC'D BY REGISTRAR JUL 10 '61	
ADDRESS Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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7252

07443

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1 FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07449

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 76 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 215 Grand Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Virginia Last Trout				4. DATE OF DEATH Month July Day 1 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1885	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 76	IF UNDER 24 HRS. Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Robinette				14. MOTHER'S MAIDEN NAME Mary Gross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Jessie Brotemarkle, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 420.1						INTERVAL BETWEEN ONSET AND DEATH SUDDEN -----	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 1, 1961 Address (Street, city, town, or county) Cumberland, Md.							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 5, 1961	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR JUL 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

FOR STATE
WILLIAM R. R.

(M)

(I)

07443

THE NATIONAL ARCHIVES
COLLECTION OF DOCUMENTS
RELATIVE TO THE
AMERICAN REVOLUTION
AND THE
EARLY HISTORY OF THE
UNITED STATES

Albany

July 1885

To your

Albany

Albany

To your

Albany

D.O. Memorial Hospital

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the decedent. The law also requires that the death certificate be retained by the hospital or attending physician for a period of 10 years. The law further requires that the death certificate be filed with the State Department of Health. The law also requires that the death certificate be filed with the State Department of Health. The law also requires that the death certificate be filed with the State Department of Health.

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
7460																							
CERTIFICATE OF DEATH																							
07450																							
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 15 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE d. STREET ADDRESS RT. #4, e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) LILLIE M. TROUTMAN						4. DATE OF DEATH Month JULY Day 5 Year 1961																	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 18, 1881		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA, SOMERSET CO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME JOHN EMERICK						14. MOTHER'S MAIDEN NAME ELIZABETH BONNELL																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longestive heart failure due to 443X DUE TO Hypertensive Heart Disease and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic Heart Disease (b) Pneumonia, bilateral, etiology undetermined (c) 1 month PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from....., 1956, to.....7/5....., 1961, that (I) (we) last saw the deceased alive on.....7/4.....1961, and that death occurred at.....3:45AM..... from the causes and on the date stated above.																							
22a. SIGNATURE DR. S.G. WEISMAN M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED																	
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN						22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF July 8, 1961		23c. NAME OF CEMETERY OR CREMATORY WHITE OAK CEMETERY				23d. LOCATION (City, town or county) (State) MEYERSDALE RD #4 SOMERSET PA													
24. FUNERAL DIRECTOR'S SIGNATURE M. E. Trice						ADDRESS 325 MAIN STREET MEYERSDALE, PA		25a. REC'D BY REGISTRAR DATE JUL 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume													

M

J

ALLGAIN

CUMBERLAND

GENERAL HOSPITAL
MEMORIAL & WASHICK AVES.

LILLIE

WHITE

JOHN EBRICK

PENNSYLVANIA

MEYERSDALE

RT. 1

TROUTMAN

AUGUST 18, 1981

PENNSYLVANIA, SOREBET CO., U.S.A.

ELIZABETH BONWELL

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. S.W. WEISMAN

40 GREENE ST., CUMBERLAND, MD.

DAVID

05150

05150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7461												7451											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						c. LENGTH OF STAY IN 1b 11/15/57						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary						d. STREET ADDRESS 521 Lowell Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Ida Middle E. Last Valentine				4. DATE OF DEATH Month July Day 26, Year 19 61																			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/31/1893		9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (State or foreign country) Meyersdale, Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME John FFAHLER						14. MOTHER'S MAIDEN NAME Elmira Deal																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE				17. INFORMANT P.O.Box 599 Allegany County Infirmary Records				Address Cumberland, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Vascular Infection - Pulmonary Articulo-Sclerotic Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Residuals of Cerebral Apoplexy, Obesity (c) Left Side Hemiplegia												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from 11/15/57 , 19____, to 7/26/61 , 19____, that (I) (we) last saw the deceased alive on 7/26/61 19____, and that death occurred at ____ M, from the causes and on the date stated above.																							
22a. SIGNATURE Dr. Lee B. Mathews				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 7/27/61															
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews				22d. ADDRESS 49 Greene St., Cumberland, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 7/29/61		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY				23d. LOCATION (City, town, or county) (State) CUMBERLAND MARYLAND													
24. FUNERAL DIRECTOR'S SIGNATURE RUTH E. SILCOX				ADDRESS CUMBERLAND MARYLAND				25a. REC'D BY REGISTRAR DATE JUL 28 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hand											

93251

CERTIFICATE OF DEATH

1961

M

Allegany County, West Virginia
11/25/61
11/25/61

Allegany County Infirmary - 321 1/2 West Avenue

John E. Harrison, Jr. - 1914
1914

11/25/61

John E. Harrison, Jr. - 1914

Allegany County Infirmary Records
11/25/61

11/25/61

11/25/61

11/25/61

11/25/61

11/25/61

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VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
7462					07452					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)					
a. COUNTY ALLEGANY MARYLAND					a. STATE WEST VIRGINIA b. COUNTY HARRISON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 10 days						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART DECATUR ST. CUMBERLAND, MD.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR ROSCOE VANHORN					4. DATE OF DEATH Month JULY Day 17 Year 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 16, 1893		9. AGE (In years last birthday) 68 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Fireman				10b. KIND OF BUSINESS OR INDUSTRY NATIONAL CARBON CO.		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME ASA (DECEASED) Asa B. VanHorn					14. MOTHER'S MAIDEN NAME Nora V. Drummond (DECEASED)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 1					16. SOCIAL SECURITY NO.					17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Tachycardia 416X DUE TO (b) Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 10 June 1961 to 17 July 1961 , that (I) (we) last saw the deceased alive on 17 July 1961 , and that death occurred at 4:30 PM , from the causes and on the date stated above.										
22a. SIGNATURE L. Michael Glick M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 17 July 61			
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK, M.D.					22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/61		23c. NAME OF CEMETERY OR CREMATORY Benedum Memorial Park		23d. LOCATION (City, town or county) (State) Bridgeport, West Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland					25a. REC'D BY REGISTRAR DATE JUL 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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Ventricles
 Tongue

451 12 12 12

• G. M. MONTGOMERY •

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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VR A15 (4)
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7463
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07453

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>40 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>506 PARK STREET</u>				d. STREET ADDRESS <u>506 PARK STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ARMONDALE</u> Last <u>VEACH</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>19 61</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 12, 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>61</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ABEL VEACH</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE HIGH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 20 5048</u>		17. INFORMANT <u>KATHRYN VEACH</u>		Address <u>CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophied Prostate</u> (c) <u>Atherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 min</u> <u>5 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 19 61</u> to <u>July 8 19 61</u> , that (I) (we) lost the deceased alive on <u>July 6 19 61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clay Durrett</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLAY DURRETT</u>				22d. ADDRESS <u>CUMBERLAND, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HIGH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PURGITTSTVILLE, W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u> ADDRESS <u>CUMBERLAND, MD.</u>				25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Hays</u>	

CERTIFICATE OF DEATH

6222

(M)

(1)

STATE OF NEW YORK

IN SENATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7464

07454

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		e. STREET ADDRESS R.D. #1, Box 69 (Shaft)	
3. NAME OF DECEASED (Type or print) GEORGE WADE		f. DATE OF DEATH 7 23 19 61.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1881
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enoch Wade		14. MOTHER'S MAIDEN NAME Weinault	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-6587	
17. INFORMANT Mrs. Della B. Wade, R.D.#1, Box 69 (Shaft)		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Cardiovascular Disease (c) NONE		INTERVAL BETWEEN ONSET AND DEATH 18 hrs 20 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) NONE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7/23 19 61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/23 1961 to 7/23 1961 , that (I) (we) last saw the deceased alive on 7/23 1961 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED 7/24/61		22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.	
22d. ADDRESS 48 BROADWAY - FROSTBURG MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-61	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Houten		25. REC'D BY REGISTRAR Arthur S. Kraus	
25. ADDRESS 23 E. Main, Frostburg, Md.		25b. REGISTRAR'S SIGNATURE	
DATE JUL 31 '61			

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James Hospital

Prossburg

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Prossburg

Allegany

R. H. J. (Chief)

W. H. J. (Chief)

W. H. J.

W. H. J.

1-23-1981

60

Coal mines

Prossburg, Pa.

Prossburg, Pa.

Prossburg, Pa.

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Prossburg, Pa.

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Prossburg, Pa.

7465

CERTIFICATE OF DEATH

Reg. Dist. No. 07455

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 mos., 25 das. 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SYLVAN RETREAT		d. STREET ADDRESS 445 Cumberland Street	
3. NAME OF DECEASED (Type or print) Anna Margaret Webster		4. DATE OF DEATH July 14 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 30, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 14 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Webster		14. MOTHER'S MAIDEN NAME Annie C. Voekel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Sarah Webster		Address 445 Cumberland Street, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 19 19 61 , to July 14 19 61 , that I last saw the deceased alive on July 14 19 61 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7-14-61			
ACTUAL SIGNATURE R. B. Mathews, M.D. M.D. 49 Greene St., Cumberland, Md.		PHYSICIAN'S NAME (Type) L. B. Mathews, M.D. 49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/16/61	22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland Maryland		24a. REC'D BY REGISTRAR JUL 17 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO BE RETAINED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FILE: The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, must file it in the office of the registrar. The registrar should be detached for use as the burial-transit permit. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7466

CERTIFICATE OF DEATH

07456

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke				c. LENGTH OF STAY IN 1b 6 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pratt St. Ext.				d. STREET ADDRESS Pratt St. Ext.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Bertha Frieda Whisner				4. DATE OF DEATH July 11 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 7, 1905	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Ball				14. MOTHER'S MAIDEN NAME Louise Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Glenn Whisner-Luke Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Embolus Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 12 Hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 to July 11, 1961 , that (I) (we) last saw the deceased alive on July 10, 1961 , and that death occurred at 8AM , from the causes and on the date stated above.							
22a. SIGNATURE Paul R. Wilson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 12, 1961	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson				22d. ADDRESS 114 Ashfield St. Redmont, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/61		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR JUL 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kneave	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

7467 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07457

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 715 MARYLAND AVE.		e. STREET ADDRESS NATIONAL HIGHWAY	
3. NAME OF DECEASED (Type or print) First MAYME Middle WIEGAND Last WIEGAND		4. DATE OF DEATH Month JULY Day 4 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 27, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. A. HENDRICKSON		14. MOTHER'S MAIDEN NAME MARY GORDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. WM. ODGERS, ROUTE 2, FLINTSTONE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 - 29 19 57 to 7 - 4 19 61 , that (I) (we) last saw the deceased alive on 7 - 4 19 61 , and that death occurred at 2p M, from the causes and on the date stated above.			
22a. SIGNATURE Ralph W. Ballin		22b. DATE SIGNED 7-6-61	
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22d. ADDRESS 62 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR JUL 10 61	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

07021

CERTIFICATE OF DEATH

1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7468

CERTIFICATE OF DEATH

07458

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 1 90 FROST AVENUE	
3. NAME OF DECEASED (Type or print) First VIVIAN Middle ALBERTA Last WITTIG		4. DATE OF DEATH Month JULY Day 12 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 13, 1901
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSING		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE DUTY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME LEOTA WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 214-32-3516	
17. INFORMANT OLIVER WITTIG, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Carcinoma of right breast (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Month, Day, Year Hour a.m. X p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/1/61 to 7/12/61 , that (I) (we) last saw the deceased alive on 7/12/61 , 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Martin Rothstein M.D.		22b. DATE SIGNED 7/12/61	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-15-1961	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Burt		25a. REC'D BY REGISTRAR JUL 17 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE C. L. G. & K. H. H.	

85350

of

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7469
CERTIFICATE OF DEATH
07459

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Route #3				c. LENGTH OF STAY IN 1b 14 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #3 Bedford Road				d. STREET ADDRESS Cumberland Route #3 Bedford Road			
3. NAME OF DECEASED (Type or print) First William Middle Freddie Last Zembower				4. DATE OF DEATH Month July Day 20 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1900		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Penna		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Zembower				14. MOTHER'S MAIDEN NAME Virgie Ressler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214- 87- 0468		17. INFORMANT Mrs. Bernadine Zembower		Address Bedford Road Rt #3 Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) Coronary thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — — 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumby Allen Rd		20f. City or town (County) (State) Cumby Allen Rd	
21. I certify that (I) (this hospital) attended the deceased from 2/3/57 to 7/20/61 , 19 61 , that (I) last saw the deceased alive on 7/20/61 , 19 61 , and that death occurred 7/20/61 , from the causes and on the date stated above.							
22a. SIGNATURE Richard J. Williams, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/20/61	
22c. PHYSICIAN'S NAME (Type) Richard J. Williams, M.D.				22d. ADDRESS 122 S. Centre Street Cumb. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR JUL 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(M)

X

(I)

O

1

BP

07522

TESTIFICATE OF DEATH

22



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "TESTIFICATE OF DEATH" and "M" are visible.]